



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON TEXAS 76013

Respondent Name

Insurance Co of the State of Penn

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M412-1998-01

MFDR Date Received

February 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 10, 2012: "The carrier has bundled the payment made for all the OR services which is not acceptable, all these codes have a status indicator of 'T' which means they are subject to discount only and not to be bundled. Also they have denied the OR line for HCPC 29888 stating there was no authorization. Authorization was obtained for the left knee surgery which is what this code was for therefore that denial is not correct! The appeal submitted was denied after reconsideration. "

Amount in Dispute: \$8,734.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 28, 2012: "Requestor is not owed reimbursement for CPT code 29988LT as the procedure was denied preauthorization and is not owed for CPT Code 298888 and 0232T as both procedures was unbundled."

Response Submitted by: Downs Stanford, P.C., 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 15 through 18, 2011	Outpatient Hospital Services	\$8,734.38	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Admin. Code §134.600 sets out the requirement for pre-authorization.
4. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

5. 28 Texas Administrative Code §133.305 sets out definitions and dispute sequence for disputed services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 1, 2011

- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- 39 – SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPTS SCHEDULE ALLOWANCE
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT AHS ALREADY BEEN ADJUDICATED.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- OA – The amount adjusted is due to bundling or unbundling of services.

Explanation of benefits dated January 31, 2012

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
- 39 – SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Are the disputed services denied for prior authorization eligible for MFDR?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59. The recommended payment is \$18.59.

- Procedure code 84315 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.53. 125% of this amount is \$4.41. The recommended payment is \$4.41.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68. The recommended payment is \$13.68.
- Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.16. 125% of this amount is \$3.95. The recommended payment is \$3.95.
- Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.90. 125% of this amount is \$11.13. The recommended payment is \$11.13.
- Procedure code 71020 has a status indicator of Q3, which denotes codes that may be paid through a composite APC; payment is packaged into a single payment for specific combinations of service. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of \$23.90. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$41.92. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$41.92. This amount multiplied by 200% yields a MAR of \$83.84.
- Procedure code 29873 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,064.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,238.41. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of \$1,095.62. The non-labor related portion is 40% of the APC rate or \$825.61. The sum of the labor and non-labor related amounts is \$1,921.23. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.148. This ratio multiplied by the billed charge of \$20,071.00 yields a cost of \$2,970.51. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$1,921.23 divided by the sum of all APC payments is 96.62%. The sum of all packaged costs is \$2,543.83. The allocated portion of packaged costs is \$2,457.75. This amount added to the service cost yields a total cost of \$5,428.26. The cost of this service exceeds the annual fixed-dollar threshold of

\$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$2,066.11. 50% of this amount is \$1,033.06. The total APC payment for this service, including outlier payment, is \$2,954.29. This amount multiplied by 200% yields a MAR of \$5,908.57.

- Procedure code 29999 is unbundled. Per Medicare policy, payment for this service is included in the payment for other services billed on the same claim. Separate payment is not recommended.
 - Procedure code 0232T is unbundled. Per Medicare policy, payment for this service is included in the payment for other services billed on the same claim. Separate payment is not recommended.
 - Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 93005 on date of service July 15, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.36. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of \$14.47. The non-labor related portion is 40% of the APC rate or \$10.90. The sum of the labor and non-labor related amounts is \$25.37. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$25.37. This amount multiplied by 200% yields a MAR of \$50.74.
 - Per Medicare policy, procedure code 93005 on date of service July 18, 2011, may not be reported with procedure code 29888 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
4. Procedure code 29888. Texas Administrative Code 133.305 (4)(B) defines prior authorization denials as, “a medical necessity dispute, which may be: (i) a preauthorization or concurrent medical necessity dispute; or (ii) a retrospective medical necessity dispute and 133.305(b) details order in which details must be resolved, “Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021. Therefore procedure code 29888 is not eligible for medical fee dispute.
5. The total allowable reimbursement for the services in dispute is \$6,098.66. This amount less the amount previously paid by the insurance carrier of \$6,192.06 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 22, 2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.